



## ELIGIBILITY REVIEW

IDENTIFICATION OR CASE NUMBER

1. PRINT YOUR NAME: FIRST MIDDLE LAST			2. YOUR TELEPHONE NUMBER		
			HOME	WORK	MESSAGE
3. ADDRESS WHERE YOU LIVE					
STREET		CITY		STATE	ZIP CODE
4. MAILING ADDRESS IF DIFFERENT					
STREET		CITY		STATE	ZIP CODE
5. I/WE NOW RECEIVE		6. I/WE NEED		7.	
<input type="checkbox"/> Money		<input type="checkbox"/> Money		Do you have trouble speaking, reading, or writing English? YES NO	
<input type="checkbox"/> Food Stamps		<input type="checkbox"/> Food Stamps		<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> Medical		<input type="checkbox"/> Medical		Do you need an interpreter? If yes, we will provide one. <input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> Nursing Home Care		<input type="checkbox"/> Nursing Home Care		If yes, what language do you speak? _____	
		<input type="checkbox"/> Drug/alcohol treatment			
		<input type="checkbox"/> Other:			

8. If you want another person to get or use your food stamp benefits for you, complete the following:

Their name \_\_\_\_\_ Telephone number \_\_\_\_\_

### PLEASE READ

**A. This review is to see if you can still get money, medical and/or food stamp benefits. If you need help completing any part of this form, let us know.**

**B. Please complete this form and mail or bring it to your local Community Service Office within ten days.**

1. We may ask you to come into the office for an interview.
2. We may ask you to verify your situation or answers you gave on this form.

**C. If you are not getting food stamp benefits now, but have requested them in question six above:**

1. We will base your food stamp benefit amount on the date we get this form.
2. Complete question 13, and you may get Food Stamp benefits within five days if:
  - a. You have very little income or resources, or
  - b. Your income and resources do not cover your monthly rent/mortgage and utilities, or
  - c. You have no place of your own to live, or
  - d. Your household includes a migrant or seasonal farm worker.
3. You must give us a Social Security Number or apply for one for each household member as required by law.

**D. If you get food stamp benefits now and do not want them stopped, turn this form in no later than the 15th of next month. We will see if you are still eligible.**

### VOLUNTARY INFORMATION

We ask that you voluntarily show your race or ethnic background. This information will not be used in considering your eligibility for benefits.

☐ Caucasian ☐ Hispanic ☐ Black ☐ American Indian/Alaskan Native ☐ Vietnamese/Laotian/Cambodian  
☐ Other Asian or Pacific Islander ☐ Other \_\_\_\_\_

# ELIGIBILITY REVIEW

## GENERAL INFORMATION

9. I need special assistance because I am:

☐ Visually impaired      ☐ Hearing impaired      ☐ Cannot read      ☐ Other: \_\_\_\_\_

10. List yourself and everyone living at your address. **Use legal names.**

DO NOT USE NICKNAMES. If you do not know a social security number, leave it blank.

NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO YOU	BIRTHDATE (MO/DA/YR)	SOCIAL SECURITY NUMBER	SEX M or F	U. S. CITIZEN		LAWFULLY ADMITTED FOR PERMANENT RESIDENCE?		IN SCHOOL?	
					YES	NO	YES	NO	YES	NO
A.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. IF ANYONE IN YOUR HOUSEHOLD HAS USED ANOTHER NAME (MAIDEN OR MARRIED NAME) OR SOCIAL SECURITY NUMBER, PLEASE LIST THE OTHER NAMES AND/OR SOCIAL SECURITY NUMBERS

OTHER NAME	SOCIAL SECURITY NUMBER	OTHER NAME	SOCIAL SECURITY NUMBER
A.		C.	
B.		D.	

12. LIST ANYONE WHO MOVED OUT OF YOUR HOME SINCE YOUR LAST REVIEW.

NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO YOU	BIRTHDATE (MO/DA/YR)	DATE MOVED OUT
A.			
B.			
C.			

13. FILL THIS OUT ONLY IF YOU DID NOT GET FOOD ASSISTANCE/STAMPS THIS MONTH, ARE NOW APPLYING AND NEED THEM WITHIN FIVE DAYS.

	YES	NO	IF YES, GIVE AMOUNT
I (we) have money in cash, checking, or savings .....	<input type="checkbox"/>	<input type="checkbox"/>	\$ .....
I (we) received money, cash, checks (income) this month .....	<input type="checkbox"/>	<input type="checkbox"/>	\$ .....
I (we) expect to get money, cash, checks (income) this month .....	<input type="checkbox"/>	<input type="checkbox"/>	\$ .....
I (we) have a rent or mortgage cost each month .....	<input type="checkbox"/>	<input type="checkbox"/>	\$ .....
I (we) have utility costs (e.g., gas, oil, electric) this month .....	<input type="checkbox"/>	<input type="checkbox"/>	\$ .....
My (our) money, cash, checks (income) recently stopped .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when? .....
I am (we are) a migrant or seasonal farm worker .....	<input type="checkbox"/>	<input type="checkbox"/>	
I am (we are) homeless .....	<input type="checkbox"/>	<input type="checkbox"/>	

14. Check any of the following situations which apply to anyone in your household

<input type="checkbox"/> Pregnancy (due date) _____	<input type="checkbox"/> No food or food money	<input type="checkbox"/> No place to live
Name of pregnant household member: _____	<input type="checkbox"/> Medical emergency	<input type="checkbox"/> No heat
	<input type="checkbox"/> Utility shut-off notice	<input type="checkbox"/> Eviction notice
	<input type="checkbox"/> Domestic violence victim	

15. How many persons in your household do you buy and prepare food for?  
\_\_\_\_\_

## FOR OFFICE USE ONLY - EXPEDITED SERVICE SCREEN

16. Household eligible for expedited service ..... ☐ YES ☐ NO

EXPEDITED SERVICE SCREENER'S SIGNATURE

DATE

# ELIGIBILITY REVIEW

## GENERAL INFORMATION (Continued)

17. Marital status - I am now: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed YES NO
18. A family member is temporarily out of the home ..... ☐ YES ☐ NO  
 Who? ..... Where? .....
19. I am (we are) living in: ☐ Own home ☐ Adult family home ☐ Congregate care facility ☐ Group home  
☐ Adult residential treatment facility ☐ Other .....
20. If someone moved into your household since your last review, answer questions A through F. about that person.  
 Name: ..... Date moved in: .....  
 A. They intend to live in Washington ..... ☐ YES ☐ NO  
 B. They have applied for or received assistance in Washington or another state..... ☐ YES ☐ NO  
 If yes, where: ..... Dates: .....  
 C. For a family now applying with both parents (married or unmarried) in the home, list the parent who earned the most money in the last 24 months.  
 Parent's name: .....  
 D. They are a veteran of the armed services, a dependent or spouse of a veteran ..... ☐ YES ☐ NO  
 E. They get food from an Indian food distribution program ..... ☐ YES ☐ NO  
 F. They are a sponsored alien ..... ☐ YES ☐ NO  
 If yes, name and address of sponsor: .....  
 21. I am (we are) a boarder (pay someone to provide my (our) meals) ..... ☐ YES ☐ NO  
 22. I (we) expect changes in my (our) situation in the next two months ..... ☐ YES ☐ NO  
 If yes, describe: .....

## MEDICAL INFORMATION

23. A. I (we) have unpaid medical bills ..... ☐ YES ☐ NO  
 B. I (we) need help with medical bills incurred in the last 3 months..... ☐ YES ☐ NO  
 C. I am (we are) in, or recently left, or plan to enter a medical facility (e.g. hospital, nursing home, etc.)..... ☐ YES ☐ NO  
 If yes, what facility(ies).....  

(1) Date Entered	(2) Date Discharged	(3) Date Will Enter
.....	.....	.....
.....	.....	.....

D. I (we) have Medicare..... ☐ YES ☐ NO  
 E. I (we) have CHAMPUS (military) coverage available..... ☐ YES ☐ NO  
 F. I (we) have health insurance..... ☐ YES ☐ NO  
 (This includes any insurance you or someone else pays for, such as private insurance, long term care insurance, group insurance through your employer or union, etc.)  
 G. I (we) had medical insurance through employment anytime in the last 3 years..... ☐ YES ☐ NO  
 H. I (we) have turned down medical coverage through employment because of its cost ..... ☐ YES ☐ NO  
 I. I (we) have had an accident requiring medical care..... ☐ YES ☐ NO

**ELIGIBILITY REVIEW**

**RESOURCES**

24. A. I (we) own or have a share in one or more of the following (check yes or no for each item):

RESOURCES	YES	NO	TOTAL AMOUNT/VALUE	HOW MANY	WHERE
Money on hand (cash)	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Checking account	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Savings account/certificates of deposit	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Credit union	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Retirement fund, IRA, KEOGH, etc.	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Money held by others	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Stocks/bonds/mutual funds	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Trust or annuity account	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Life insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Prepaid funeral plan (not life insurance)	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Money for funeral/burial	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Burial plots	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Sales contract	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Property on which you live	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Property on which you are not living	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Business equipment (tools, machinery)	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Livestock (horses, cattle, sheep)	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Timber/crops	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Other	<input type="checkbox"/>	<input type="checkbox"/>	\$		

B. I (we) have or am (are) buying a car or other vehicle (truck, boat, camper, trailer, motor home, snowmobile, motorcycle, etc.) ..... YES NO  
☐ ☐

ITEM	YEAR	MODEL	VALUE
			\$
			\$
			\$
			\$

C. I (we) use a vehicle for medical purposes..... YES NO  
☐ ☐  
D. I (we) use a vehicle for employment ..... YES NO  
☐ ☐  
E. I (we) have sold, traded or given away a resource (see A and B above) in the last 2 1/2 years..... YES NO  
☐ ☐  
If yes, explain:  
What? ..... To whom? .....

**EMPLOYMENT**

25. A. I am (we are) working or have worked since the last review (include self-employment) ..... YES NO  
☐ ☐  
If yes, have you been sending regular earnings reports to your financial worker ..... YES NO  
☐ ☐

**LIST HOUSEHOLD MEMBER'S EMPLOYMENT**

PERSON	EMPLOYER	HOURS WORKED EACH MONTH	LAST DATE WORKED
1.			
2.			

B. I am (we are) able to work (adults) ..... YES NO  
☐ ☐

**IF NOT ABLE TO WORK LIST WHO AND WHY**

PERSON	REASON
1.	
2.	

# ELIGIBILITY REVIEW

## EMPLOYMENT (CONTINUED)

YES NO

C. Within the last 60 days I (we) left a job ..... ☐ ☐

If yes, person's name: \_\_\_\_\_ Employer: \_\_\_\_\_

Reason: ☐ Laid off ☐ Fired ☐ Refused work ☐ On leave of absence ☐ Injury  
☐ Quit work ☐ On strike ☐ Refused training ☐ Illness

## INCOME

26. I (we) **receive** or **have applied** for money from the following sources (check yes or no for each item):

INCOME	YES	NO	PERSON WITH INCOME	AMOUNT	PERSON WITH INCOME	AMOUNT
Earnings (wages)/commissions	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Public assistance	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Unemployment compensation	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Social Security benefits (SSA)	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Supplemental Security Income (SSI)	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Railroad benefits	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Retirement/pension	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Child support/alimony	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Insurance benefits	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Trust or annuity	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Money from roomers/boarders/renters	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Money from relatives/friends	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Veteran's benefits	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Labor and Industries	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Military allotment	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Income tax refund	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
School grants or loans	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Cash Prizes (bingo, lottery, etc.)	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Other loans	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$
Other income	<input type="checkbox"/>	<input type="checkbox"/>		\$		\$

## EXPENSES

27. A. I (we) have a housing cost (if yes, give amount below): ☐ Yes ☐ No

1. Rent ..... \$ ..... Property Taxes ..... \$ .....  
Mortgage ..... \$ ..... Property Assessments ..... \$ .....  
Space Cost ..... \$ ..... Homeowner's Insurance ..... \$ .....

YES NO

2. Someone pays all or part of my (our) housing costs or utilities. .... ☐ ☐

3. I am (we are) responsible for: Heating/cooling costs ..... ☐ ☐  
Other utilities ..... ☐ ☐

Electricity: \$ ..... Telephone: \$ ..... Garbage: \$ ..... Other: \$ .....  
Heating Fuel: \$ ..... Sewer: \$ ..... Water: \$ .....  
(oil, gas, wood, etc.)

B. I (we) have dependent care or babysitting expenses: ☐ Yes ☐ No If yes, amount: \$ .....

C. I (we) make court ordered child support payments: ☐ Yes ☐ No If yes, amount: \$ .....

## READ CAREFULLY BEFORE SIGNING

### I UNDERSTAND THAT:

- I (we) must report immediately to the Department of Social and Health Services (DSHS) Community Services Office, in writing, any changes in my situation. Late reporting may cause incorrect benefits.
- I (we) must provide proof I (we) am eligible for help. DSHS may help me (us) obtain the proof or contact other persons or agencies for it.
- **The information I (we) give here is subject to verification by state and federal officials to decide if I am eligible for benefits and the amount I will receive.** This may include unannounced contacts by the Office of Special Investigation.
- **My (our) Social Security Number(s) will be used by state and federal agencies to check identity of household members, to prevent duplicate participation, and to exchange information by computer with other agencies (e.g., Social Security Administration, Internal Revenue Service, employers, and banks) to verify eligibility.**
- By asking for and receiving Aid to Families with Dependent Children (AFDC) or Food Stamp benefits, persons aged 16 to 60 may be required to participate in an employment or training activity.
- By asking for and receiving financial benefits, I (we) assign to the State of Washington all rights to any support, including child support and medical care support.
- By asking for and receiving medical care benefits, I(we) assign to the State of Washington my(our) rights to medical care support and any third party payments for medical care to pay for covered medical services while receiving medical care benefits.
- The department may recover the cost of long term medical care services if I (we) am 55 or older from my (our) estate. Long term care includes COPES, Medicaid Personal Care, and nursing home services plus related hospital and prescription drug costs.
- I(we) may be restricted to one physician and pharmacy if I (we) misuse my (our) medical benefits.

### FOOD STAMPS PENALTY WARNING

**If you use or receive Food Stamps to buy or sell firearms, ammunition, or explosives, you may be barred from the Food Stamp Program permanently for the first violation. For using or receiving Food Stamps to buy or sell a controlled substance, you may be barred 12 months for the first violation and permanently for a second violation. For intentionally violating any other Food Stamp Program rule, you may be barred for 6 months for the first violation, 12 months for the second violation, and permanently for the third violation. In addition, a court may bar you for an additional 18 months.**

- DO NOT:**
- Give false information or hide information.
  - Trade or sell Food Stamps or authorization cards;
  - Alter authorization cards to get more Food Stamps than you are eligible to receive;
  - Use Food Stamps to get ineligible items such as alcoholic drinks and tobacco; or
  - Use someone else's Food Stamps or authorization cards for your household.

**If you knowingly and intentionally break a rule, you can be prosecuted and fined up to \$250,000 or imprisoned up to twenty years, or both. You are also subject to prosecution under other applicable federal laws.**

### GENERAL ASSISTANCE PENALTY

If you are convicted by a court of illegally receiving General Assistance, you will be barred from receiving cash and medical assistance for the period determined by the court.

### DECLARATION AND SIGNATURE

I/we have read (or had explained to me/us) and understand the information in this application. I/we declare under penalty of perjury, information I/we gave in this application is true, correct and complete to the best of my/our knowledge. I/we understand that I/we can be criminally prosecuted if I/we incorrectly receive cash, food stamps, or medical, because I/we have made a willfully false statement or because I/we have willfully failed to report something I/we should report.

**Only one applicant must sign if applying only for Food Stamps.**

**If applying together for money or medical help, all adult household members must sign.**

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF OTHER ADULT HOUSEHOLD MEMBER	DATE
SIGNATURE OF WITNESS IF APPLICANT SIGNED WITH AN "X"	DATE	SIGNATURE OF WITNESS IF SPOUSE SIGNED WITH AN "X"	DATE
SIGNATURE OF HELPER	DATE	SIGNATURE OF HELPER	DATE